MEDICAL ASSISTANCE FOR THE AGED—II*

REPORT BY THE
COMMITTEE ON PUBLIC HEALTH
THE NEW YORK ACADEMY OF MEDICINE

FOR the past seven years it has been repeatedly asserted that the elderly need help in meeting expenses for illness. To support this inference several lines of evidence are presented. There are more elderly citizens, both absolutely and relatively, in the population. The elderly have more and longer illnesses with more and longer hospitalization. It is this group that constitutes medicine's new challenge: diseases of the elderly, usually chronic diseases. It is stated that the cost of hospitalization has risen and will continue to rise. And finally, it is emphasized that the elderly are past their most productive period of income. These particular circumstances characterize this age group and affect its ability to meet the cost of medical care. It is concluded therefore that a substantial portion of them are unable to cope with costly illness.

In further elaboration, it is stated that some of the elderly are not receiving necessary medical care—here the term includes physicians' services and hospitalization—because they cannot afford it. Others are said to postpone or curtail necessary medical care so that in effect they may be said to be receiving inadequate medical care. Still others, it is said, are being or would be impoverished by the cost of medical care. There is no general acceptance or agreement on all these statements. But few would dispute the assertion that some of the elderly need help in meeting medical expenses. Indeed, this appears to be one statement that is seldom questioned or challenged.

With this basic agreement, it is interesting that this topic has become one of the most emotionally charged, stridently argued, and sharply divisive issues over the past decade. The debate is not over whether some of the elderly need financial help to meet their medical expenses. Rather, it is over the size of the problem and what help should be provided and how, particularly the latter.

How many need help? Before formulating any program of help it is desirable, if not essential, to know the magnitude of the problem in terms of the number of prospective beneficiaries. A logical course that might be expected to lead to the right answer would be to analyze the problem, to define it in precise and specific terms. But what appears to be a simple straightforward matter is in actuality found to be much more diverse and complex. Strange as it may seem, the figure on the number needing help has not been precisely stated. It is still in the form of an estimate.

It is not difficult to specify who may be excluded from the count of the medi-

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cally needy. They are these groups: high income; little or no income; institutional; those receiving or eligible to receive service benefits; and those with insurance. The remainder, the object of concern, are readily placed as being in the low- and middle-income groups.

But enumeration of the medically needy still remains difficult. Essentially the category of medical indigency arises from the relation of the cost of illness to the individual's financial resources. It is obvious that the operation of this ratio contains the elements of immediate as well as long futurity, contingencies, and a number of variables.

At any time it is not easy to decide who needs or will need help in defraying medical costs. It is difficult to set arbitrary standards properly that are neither too strict nor too lax. From the uncertainty and variation both in economic means and occurrence and nature of illness, it is difficult to predict probable events and count the number who will need help in meeting the critical cost of illness.

It might be expected that turning to the past record might provide the basis for calculation for the future. There have been many data and calculations on the elderly which have been widely cited. Mainly these figures have been provided by the Census Bureau, the Department of Health, Education and Welfare, and the Michigan Survey Group. There have been data on the elderly in respect to their increasing number, employment status, income, assets, debt, insurance, morbidity, and hospitalization. If the elderly are not the most completely described age group statistically, they come close to achieving this distinction.

But the appropriateness of some of the data has been challenged. Furthermore, interpretation of the figures and inferences drawn from them have not escaped criticism. It is pointed out that the economic status of the elderly is diverse, complex, and difficult to analyze. A proportion of them have a number of financial resources. Hence, in fixing criteria that would permit counting the medically needy, it is argued that all resources should be considered, not just income. It is further averred that calculation of income should be by family, not per capita. Also, using a median figure for income has been branded as misleading. Not to be overlooked is the effect of social security benefits on earned income; for persons under 72, the former are reduced if the latter exceeds $1200 during the year. These are some of the reasons for difficulty in setting bounds that would delineate the medically needy group and taking a census of them.

Statistics on the other member of the ratio, cost of illness, have also come under criticism. The source and basis for the figures have been questioned. Then too, reporting of higher hospital utilization by the elderly in patient days, rather than in number of patients, may emphasize the need but does not permit delineation of the magnitude of the problem in terms of the size of the ill group. Furthermore, there is difference of opinion over whether the most pressing need of the elderly is indeed hospitalization or medical care whether at home, in the physician's office, or in a nursing home. This is no academic point; for, it has a profound effect on the cost of medical care. These criticisms and the disagreement over the cost of medical care for the elderly affect the delineation of the medically indigent and the counting of the number in that category.

Moreover, there is dispute over whether voluntary insurance has grown at a sufficiently rapid rate to be regarded as a substantial influence on diminishing the

magnitude of the medically indigent. Regardless of the answer, it should be emphasized that so recent is the development of health insurance that most of the present aged did not have the opportunity for it during their working years.

To make the matter more complex, all the variables influencing the resources, illness, and its cost undergo change with contingencies.

From all this, it is evident that the medical needs of the elderly are far from being uniform and that their economics are so diverse and complex that their ability to meet medical expenses is not easily defined. In consequence, broad generalizations concerning the subject are frequently uttered.

It should be noted that some think that the present situation with its combination of circumstances, particularly the large proportion of elderly in the population, is temporary and transitory, and that it will become less intense in the future. But others regard the present state as part of a definite trend that is likely to become accentuated. It cannot be denied that the answer to this question has a bearing not only on whether something should be done to help those elderly who cannot cope with their medical expenses, but also on the choice of method to provide the assistance. Still, most think that some elderly need help in meeting expenses for illness and that there will always be some that should receive it.

Although the number of the medically needy among the elderly is not known and there is difference of opinion over the benefits most needed by them, it is the means of financing help for them that has been a major, if not the principal point, of controversy. There are two possible main approaches: the one is extension of aid to the medically indigent when illness arises with funds from the federal treasury; the other is insurance embracing all since it is impossible to predict which persons will incur illness and need financial aid. This insurance may be written by the government, by private nonprofit companies or by commercial carriers. Or, the government may purchase insurance for its elderly citizens.

Developments in Congress

During the 1940's the Wagner-Murray-Dingell bills, which were being widely discussed, would have covered persons of all ages, including the elderly. The first step specifically for aged was taken in Congress when the Forand bill was introduced a few days before closing in 1957. It gained momentum through 1958 and 1959. It was a program of compulsory health insurance to provide prepaid hospital and surgical benefits in service rather than cash for those eligible under the Old Age and Survivors Insurance System. The health insurance was to be incorporated in the Social Security program and financed by Social Security taxes. This bill had numerous highly vocal proponents and opponents.

During March and April 1960 the press reported that Congressional leaders were considering a limited program based on principles similar to those in the Forand bill.

The next development came in October 1960 when Congress put into effect the Kerr-Mills bill as an amendment to the Social Security law. It was designed to provide broad health service to the medically indigent aged, i.e., those persons who are not on relief, can meet their daily living expenses, but cannot cope with the cost of medical services. It provided assistance through federal grants to states. Depending on the state's per capita income, it would receive from the

federal government, out of the general tax revenue, 50 to 80 per cent of its costs of care, and 50 per cent for administration. There was no ceiling on the total federal appropriation, but to receive funds each state must pass enabling legislation and appropriate funds.

Provisions in this federal law for benefits under Medical Assistance to the Aged (MAA) are indeed broad. States may use MAA money in such major categories as hospitalization, nursing home care, physicians' service, prescription drugs, and dental care. However, a state program must include at least one institutional and one noninstitutional type of benefit.

With a new administration the program for medical care of the elderly which many of its leaders had been espousing appeared in February 1961 embodied in the King-Anderson bill. It provided coverage for all persons 65 or over who were eligible for benefits under the Social Security and Railroad Retirement Acts. Its benefits comprised inpatient hospital services up to 90 days; nursing-home services up to 180 days; home-health services up to 240 visits a year; and outpatient hospital diagnostic services. Essentially it covered the cost of hospital and nursing-home services and care. Both the inpatient and outpatient hospital services were, however, made subject to a deductible clause. Not included were mental and tuberculosis hospitals; a private physician's services in the hospital; office or house call; and drugs outside the hospital or nursing home. The bill would be financed by increasing the taxable earnings base and rate of contribution to Social Security.

The number of possible single and separate ways of providing help to the medically needy among the elderly is three: private insurance, public insurance, and postpayment by public assistance. By 1962 two were already in effect; the third, public insurance, was being pressed for adoption. Each approach was then judged separately on the basis of its ability to do the whole job. It was by this criterion that comparisons were made. Arguments for one carried criticism of the others.

Private insurance was in the field first. Although policies for voluntary health and hospital insurance have been written for many years by private companies, both nonprofit and commercial, those for health terminated in the main at age 65. In consequence, persons now over 65 had not had the opportunity to purchase health insurance during their productive years. But by 1962 policies were being offered that would remain in effect after age 65. At about the same time insurance companies, by waiver of legal restrictions, were permitted to join in offering several uniform policies designed specifically for those already 65 or over.

In one of the most frequent arguments against private insurance it has been asserted that as judged by its slow rate of growth, it has not proved adequate to meeting the need. Limited benefits and costly premiums have been blamed. Further arguments have been: numerous independent companies do not constitute an organized, unified national system; the multiplicity of policies with complicated schedules of benefits and rates makes it difficult to earmark reserves; experience rating operates to the economic disadvantage of the elderly; the practices of group insurance and movement of workers from job to job necessitate repeated changes. In reply supporters of private insurance point out that in its new forms it has not been in operation for an extensive period, and that it has made vast strides in a short time. In consequence, they insist, it is premature to pass judgment on it at so early a date.

Since its inception MAA has been under attack from one or another quarter. It has even been suggested that it came into being as a means of thwarting a public insurance plan. More and more there developed an attitude toward it that it was not adequate as a national system, but that it had a limited usefulness. From a review of MAA in its three years of operation, a majority report of a Congressional Committee presented the most comprehensive critique. The principal criticism was its low rate of utilization. This in turn was attributed to its failure to become a national system since not all states had established MAA programs. Among those states which had active programs, benefits were found to be highly variable and mostly limited. Unrealistic restrictions on eligibility were also mentioned. Those supporting MAA countered that it had not been in operation for sufficient time to judge its effectiveness, that it was making satisfactory progress, and that soon it could be expected to fulfill its vast potentialities.

Since introduction of the King-Anderson bill in 1961 as a prototype of public insurance, proponents of it have continued unabatedly attempts to obtain passage of it. Among the several arguments advanced against it, these are perhaps heard the most frequently: 1) That its benefits are restricted to hospitalization; it is therefore inadequate and indeed does not meet the most frequent need of the elderly. 2) That it is linked to Social Security and that ultimately this union may bring about a profound change in the American system of hospitalization and practice of medicine. 3) That the costs have been grossly underestimated and that contributors may expect to pay increasing amounts in the future. 4) That it establishes a tax that would remain in perpetuity though later it may not be needed. 5) But perhaps the biggest and deepest source of opposition is not easily demonstrable. It is not improbable that its greatest handicap is that it is patterned after the National Health Insurance Act which was the center of a hot controversy a number of years ago and left scars. Perhaps public insurance for the elderly has inherited the liabilities as well as the assets of that plan which aroused emotions to high pitch.

Various Bills Introduced

Over the past three and one-half years there have been attempts to modify each of these approaches to meet criticism, to minimize or remove objectionable features, and to strengthen weak points. Gradually it was realized that no one approach may be adequate; and that combination may provide a more comprehensive and effective plan. Numerous bills reflecting these developments have been introduced. Some of the better known may be briefly reviewed.

Basically similar to King-Anderson in financing and benefits was the bill introduced by Lindsay in 1962. It had two additional features: an option to purchase private insurance; under a supplementary health benefit system, special provision for those not eligible under the Social Security system. By this latter provision all persons 65 or over would be eligible and covered. A Federal Health Insurance Trust Fund would be created.

Measures for wider application of voluntary insurance were also embodied in bills. In April 1960 Senator Javits had introduced a bill into Congress to assist states in establishing plans for voluntary health insurance for the elderly with the aid of federal matching grants based on the formula in the Hill-Burton Hospital

Construction Act. It provided both service and indemnity types of benefits. Its service type included 60 days in a hospital or nursing home, medical care in the home or physician's office, and laboratory tests. Insurance was to be placed with either commercial or nonprofit private insurance carriers under contract with a state agency.

In March 1962 Congressman Bow introduced a bill to provide for the medical and hospital care of the aged by subsidizing voluntary health insurance through federal income tax credits. Everyone 65 or over, regardless of income, would be eligible for this credit, as would anyone who paid premiums for an aged dependent. Approved renewable insurance policies would have to conform to one of two plans to meet standards in provision of benefits. These plans differed in the number of benefits, the allowance for each, and the maximum. One would cover hospitalization with ancillary charges; convalescent care; and surgical charges. The other included these services as well as those of a physician and a registered nurse, prescribed drugs, diagnostic x ray, and radiation treatment. The program would be administered by the U.S. Treasury Department through private insurance plans.

In June 1962 Senator Morton introduced a bill to provide for federal financial participation in state programs established for the purpose of assisting individuals 65 and over in obtaining health benefits insurance on a voluntary bases. All would be eligible. In its health benefits program the state would contract with a carrier for a noncancelable type of policy and offer the beneficiary the choice of coverage for short-term or long-term catastrophic illness. Benefits could be in services or indemnity. The state and individual would share in payment of the premium, the state's share being based on the federal income tax liability of the individual. The federal government would reimburse the states.

Several bills embodied two of the three main methods of financing. In February 1961 with the appearance of the King-Anderson bill, Senator Javits introduced a bill permitting a choice of one of three options on benefits: 1) Preventive diagnostic and short-term illness service, including 21 days of hospital care; physicians' service outside the hospital for 12 days; ambulatory diagnostic services; and home care services for 24 days. 2) Catastrophic long-term or chronic illness for which 80 per cent of the cost of the following would be paid: inpatient hospital services for 120 days; inpatient surgical services; nursing home services; home care and other services. 3) Private insurance for which one-half of the premium up to $60 a year would be paid. Eligibility was restricted to those with an individual income not exceeding $3,000 or, for a couple, $4,500. Individual states would administer the plan and be reimbursed under a matching grant for the federal share which would be between 33⅓ and 66⅔ per cent, determined by a ratio of the state-federal per capita income.

Some months later Senator Javits introduced a modified version which contained the same eligibility requirements and the same categories of three options in benefits as his previous bill, but with some alteration in the details of the benefits. The principal change was in the method of financing. Since states would administer the plan, they would be reimbursed from a federal medical insurance trust fund. For Social Security beneficiaries funds would come from payroll taxes, which would be increased for employee, employer, and self-employed; for others, from general revenue.

In January 1964 Senator Javits introduced a bill embodying the recommenda-

tions of the 12-member National Committee on Health Care of the Aged. It proposed a dual public-private health insurance program, separate but complementary. It visualized the public plan being financed by use of the principle of contributory social insurance, with a separately designated payroll tax collected as part of Social Security tax.

The report regarded institutional care as the most appropriate area of protection to be provided by the public plan. As proposed, the extent of protection would amount to about one-third of the aggregate health care costs of the aged.

The private insurance plan was envisioned as covering the largest noninstitutional costs that occur most frequently among the aged, for the most part physicians' care. This plan would take care of another one-third of the cost.

The National Committee set forth guiding principles for both public insurance and complementary private insurance. With the public plan the fundamental long-range objective should be progressive improvement in the quality of the services financed through the plan.

For complementary private insurance, the guiding principles were that it should be available to all without disqualifications, reduction of benefits, or increases in premium. Intensive efforts should be centered on marketing methods designed to produce high-volume, low-cost mass coverage. Companies should be enabled to join in nationwide concerted efforts. To increase the proportion of the aged covered under private insurance in the future, methods for prepaying during the years of active employment should be developed. Those retired should be continued under group insurance plans.

Viewing the components of the dual program as mutually re-enforcing and dependent, the Committee urged the establishment of a National Council on Health Care of the Aged.

Attempts have likewise been made to increase the effectiveness of MAA by proposed amendments. In December 1963 Senator Scott offered a bill that would permit states in administration of their MAA plans to cooperate with voluntary nonprofit health insurance groups in order to facilitate coverage by health insurance of those eligible for MAA.

A voluntary program built upon MAA rather than replacing it was contained in a bill presented by Senator Saltonstall in April 1964. A state to participate in this program must have an MAA program in effect. The bill would extend benefits to those not eligible for assistance under MAA and provides an alternative to those enrolled under MAA. Three options in benefits are available to individuals: 1) A preventive diagnostic short-term plan which would provide as a minimum 21 days of inpatient hospital services, including physician, nursing as well as laboratory and x-ray services; 63 days for nursing-home care; surgical services provided in a hospital; physicians' services for 12 days outside a hospital; and $100 of ambulatory diagnostic laboratory and x-ray services outside a hospital or nursing home, as well as other additional services. 2) Long-term illness plan which would provide as a minimum 120 days of inpatient hospital services; nursing-home care; drugs; diagnostic laboratory services, including x ray up to $200; outpatient hospital services; physicians' services including surgery. Payment would be made for not less than 80 per cent nor more than 90 per cent of the costs of the above in excess of $50. 3) Private insurance policy. There is no means test but by income limitation individuals able to meet their own medical costs are excluded. Individuals

would be required to pay an enrollment fee which would vary with income and would thereby contribute to the plan.

This bill specifies federal-state matching and state administration. Federal grants would cover 50 per cent of state administrative costs and from 60 to 80 per cent of other costs, depending upon the state's per capita income with a ceiling on the federal share of contribution for an individual.

Since the enactment of MAA in 1960 the American Medical Association has twice set forth its proposals to make it effective. Within a month of its passage the Association recommended standards for it. In a report adopted by the House of Delegates it said:

> Medical Assistance for the Aged [should] not be limited to the group within some fixed income-and-resources level, but should be based on the individual applicant's medical needs and his ability to pay for care without compromising those resources essential to his retaining self-supporting status after completion of treatment.
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> In Medical Assistance for the Aged, any type of treatment or facility medically necessary to the individual's care [should] be included within the possible range of assistance, but that aid [should] be provided in meeting only the costs of those services which are beyond the individual's means rather than all treatment costs for each case.

In hearings in November 1963 before the Committee on Ways and Means of the House of Representatives the AMA issued a statement of policy concerning MAA which had been adopted by its Board of Trustees. For the purpose of adding to the flexibility and effectiveness of the MAA program the policy called for changes in the Kerr-Mills law itself:

1) Remove the requirement that both medical Old Age Assistance (OAA) and Medical Assistance for the Aged (MAA) programs be administered by the same agency;
2) Provide flexibility in the administration of the income limitations proposed under state law so that a person who experiences a major illness may qualify for benefits if the expense of that illness, in effect, reduces his money income below the maximum provided;
3) Include a provision in the law requiring state administering agencies to seek expert advice from physicians or medical advisory committees; and
4) Make "free choice" of hospital and doctor mandatory under state programs.

These were the developments and this was the situation when the Committee on Public Health once again entered upon deliberations of means for providing medical care for the medically indigent.

Committee's Current Deliberations and Decisions

At the beginning of its present sessions the Committee raised as the first question to be answered: just who among those 65 or over need help in defraying their medical expenses? It was easier to reach an answer by enumerating first those who did not need help. It was obvious that those with a high income could afford to meet their medical expenses. At the other end of the economic scale it was equally apparent that there was provision for the indigent to receive medical care under OAA. Somewhere between these two groups, in the low- and middle-income brackets, were likely to be found those in need of help for medical expenses. But even among these groups there would be those receiving or eligible to receive service benefits and those with insurance. Of the remainder in these

income groups, only a proportion would need help in meeting medical expenses. These are the medically indigent, so-called because they can meet the ordinary living expenses but are unable to cope with medical expenses beyond the lowest. In short, their medical expense exceeds their ability to pay.

It is difficult to assign absolute financial limits to medical indigency. It arises from the relation of the cost of illness to the individual's financial resources. This relation is best expressed as a ratio. It becomes apparent that medical indigency may occur over a wide range of income.

Operation of this ratio brings out another striking situation that reveals a second group equally worthy of concern. It may not only reflect an inability to meet medical expenses, but also a situation whereby payment of medical expenses will wipe out resources. If those in the latter group met their medical expenses, they would be plunged into distress. As a guiding principle it was the opinion of the Committee that illness should not impoverish; it should not create indigency. It went beyond that in expressing its belief that the expense of illness should not bring a marked change in the way of living.

This second category of elderly in need of help merges with that characterized by catastrophic illness with broadened application of that term. By the usual definition, catastrophic illness is thought to be on such a scale that its costs would not ordinarily be covered under any basic insurance plan. Or, otherwise expressed, catastrophic illness jeopardizes economic status to the point of leaving a person in distress. But illness can be a financial catastrophe at any level over a wide range of income. Equally true, illness can be catastrophic over a wide range of cost. For the elderly, a group with high costs from prolonged illness, catastrophe is more than a threat. Even far short of impoverishment, a change in living can be so marked as to be disastrous.

The Committee is concerned not only about those unable to meet more than minimum medical expenses, but also about those who by paying medical costs would be plunged into indigency or a markedly reduced scale of living.

In formulating a system to render help to the elderly for their medical expenses, it must be borne in mind that the present situation is probably not temporary or one-time. There are new entrants to the ranks of the elderly every year. There is every indication that in the future there will be generations of elderly in need of help with their medical expenses. In planning for a system therefore the future elderly must be considered as well as the present elderly. Appropriate and effective plans for one generation are not necessarily the same as those for the other. Indeed, they differ. Part of the present problem is that those now elderly bear the cumulative effect primarily of lack of opportunity to obtain protection. Yet there will probably always be some who reach the elderly state unprotected. Contrastingly, younger citizens have an opportunity to prepare for the medical needs of their old age that was not available to the present generation of elderly.

The magnitude of that part of the present problem comprised by the number and proportion of medically indigent among the present generation of elderly is not precisely known or quickly and easily ascertained. Nor can the number, proportion, and identity of future medical indigents be acurately predicted. It is difcult to foretell whether the present proportion, whatever it is, will remain, diminish, or increase. In addition to other important factors, much depends on what is done today to meet these needs.

If the magnitude of the problem is uncertain, the type of health benefits that the medically indigent should receive can be more precisely determined. It is easy to recommend comprehensive care with little or no dissent, for it is a term in vogue. But it means different things to different people. Consequently it has become trite and vague; it can be unrealistic. The Committee would prefer to state that the care should be complete and adequate for the patient's needs. It should be a flexible program with optional plans. Included should be the following services: inpatient hospitalization; nursing home; home care; nursing, ambulatory diagnostic; physician and surgeon; laboratory and x ray; and prescription drugs. As for standards of quality of care—a subject of deep concern to the Committee—it realizes that across the nation there is not complete uniformity in medical services in all places at all times. Realistically it would assert that medical care for the medically indigent in a community should meet the level of the standards of good medical care prevailing there. Where the care is generally substandard, steps should be taken to improve it.

Choice of Systems

Choosing a system of providing financial help for those who are or may become medically indigent is essentially choosing a method of financing and payment. Associated with that is the administration of the plan. The choice will be among private insurance, public insurance, postpayment from general revenue.

In any comparison of the relative merits and defects of the three systems, it is not necessary to dwell upon their strong points and shortcomings. These have been thoroughly aired in the spoken and printed word; they have been enumerated briefly earlier in this report. Two cardinal principles provide valuable guidelines in reaching a decision: 1) provision of help with medical expenses of the present elderly and the future elderly are two different problems in financing; 2) no one system may be the most appropriate and effective for both. Each may require a different plan. In addition to these principles, an actuality is to be taken into account: two systems are already in effect.

After deliberating on a choice of systems in the light of these principles and circumstances, the Committee reached the conclusion that the existing systems—private insurance and MAA—were sound in concept and had much to commend them. Properly planned and administered they would have a high probability of success.

For the future elderly, insurance is the most appropriate plan since it permits policy holders to prepare in advance during their most productive years for the protection against medical expenses of old age. For those careless or tardy in obtaining this protection, another type of policy is available at 65 or over. Thus insurance protects the future as well as the contemporary elderly. It is obvious that the more people who take insurance before 65, the fewer in number will need to take it at 65.

On balance, private insurance seemed to the Committee to be more suitable and potentially just as effective as public insurance. It combines the voluntary aspect for the individual with use of private industry, both commercial and nonprofit, that are in the best American tradition.

For those who have reached 65 or over without protection and lack sufficient means to purchase it, MAA can provide adequate help to the medically indigent among them. Whatever the uncertainty about the magnitude of medical indigency, the Committee is confident that MAA properly executed would be adequate for the need. Furthermore, it is equally apparent that the more persons who subscribe to health insurance both before and after 65, the less load for MAA.

The Committee is convinced that neither private insurance nor MAA, for different reasons, has had a fair trial. This conclusion was reached not because the period had been insufficient, as has been frequently intimated, for these systems to demonstrate their adequacy. Rather it is because neither system has been applied most effectively. One, MAA, has actually been misused. Continued trial of these systems in the present manner would only add to the evidence of their incomplete application.

To have a fair trial, both systems must be improved. Indeed, the Committee concluded that in their present form and execution, both need improvement. When it recommends both private insurance and MAA, it is speaking of these systems, not as they are, but in improved forms. When these improved system are tried, there may be no need for additional steps.

Until the two systems have a fair trial, the Committee sees no point in introducing a third system, public insurance, particularly in a form that is itself inadequate. It would necessitate establishing a new and probably large bureaucracy. To take that step does not seem to be necessary, sound, or promising.

In reaching its decision of choosing improved and enhanced private insurance and MAA, the Committee would re-emphasize the need for improvement in them. It would further stress that neither system alone is or probably will be sufficient; therefore, neither should be judged as a complete program. However, the combination can be adequate.

Criticisms of both systems, private insurance and MAA, were reviewed by the Committee. This course had been helpful in the appraisal of the systems; it was useful now in ascertaining what parts of them needed improvement.

Private Insurance

Adverse comments had been leveled against private insurance as an effective national program for medical care and hospitalization on the grounds of its record and its limitations and drawbacks as an operating system. It has been frequently argued that its slow rate of growth is prima facie evidence of its inadequacy. In turn this low volume of policy holders is said to arise from restrictions, limited benefits, and high cost of premium.

Specifically, it is argued that because of restrictions, some groups are not covered. It is said that experience rating excludes many who most need insurance.

Also, limited benefits are advanced as another reason for a less than maximum number of policyholders. By restrictive provisions and riders, benefits become too limited, either absolutely or relative to premium cost. An income ceiling sometimes determines benefits. In consequence, benefits may become so limited that they are regarded as not covering a sufficient part of the policyholder's total liability in illness, that is, they do not furnish adequate financial protection against illness.

An additional reason offered in explanation of why there are not more subscribers is cost. For one thing, premiums are said to be too high, either absolutely or relative to benefits. For another, it is argued that too little of the total medical expense is met by insurance. Experience rating is criticized for increasing the cost to a prohibitory point for some groups.

An income ceiling, besides determining benefits, may require that an additional fee be paid by the subscriber. Then there is the additional aggravating incident that some physicians are said to increase their fees for patients with insurance.

In the second broad criticism of private insurance, it is maintained that an effective national program of medical care and hospitalization requires a unified system. It is asserted that private insurance is not and cannot become an organized, unified, national system for the following reasons: numerous independent companies; multiplicity of policies; complicated schedules of benefits and rates; experience rating; and migration of workers.

All these points of criticism have been answered by the insurance companies. Yet, in the opinion of the Committee, there are two important points that have not been sufficiently taken into account by either side.

First, most energy has been devoted to providing insurance for those 65 and over. But private insurance should not be judged mainly on the record of policies taken at or after 65. On the basis of the age of the insuree these policies, in accord with sound insurance principles, had to be of the annual renewable type with no reserve. There is no record by which to judge a comparably vigorous campaign for health insurance among those under 65 with a different type of policy permitting reserves and thereby lower premiums and broader benefits, the latter effective upon reaching 65.

Second, it is not unlikely that the constant agitation in some quarters for public insurance arouses an anticipation of it that to some extent retards persons from seeking private coverage. Furthermore, this atmosphere, which understandably has placed the private insurance companies in a defensive posture has not been conducive to broad thinking and all-out effort. But if the companies can cooperate as they have in writing insurance for those already 65 or over, it should not be impossible to join in meeting these criticisms in bringing about broad coverage with deferred benefits for those under 65.

In the opinion of the Committee these are the ways private insurance for medical care of the elderly can be improved: companies should continue to offer health insurance for those already 65 or over. This group would be helped in obtaining this protection by such provisions as are in the Bow bill. But more important, carriers should place more emphasis on writing health insurance to be taken under 65 for protection after 65. Because broader benefits and lower premiums should be possible for this group; and from the standpoint of the potential subscribers, their earnings in their productive period would allow them to take this protection. Industry and unions as the largest group purchasers of insurance should be alert to this possibility and should provide insurance coverage for the maximum number after retirement.

It is the belief of the Committee that private insurance companies can plan and work together with all the effect of a unified national system. From actual experience they are familiar with the methods of cooperation. Nonprofit insurance for hospitalization is already on a national scale. Indemnity benefits present no

interstate problem. Any differential in benefits of services can be settled by equalization. In the opinion of the Committee, there are no insurmountable difficulties in the operation of private insurance with the effect of a national system.

MEDICAL ASSISTANCE TO THE AGED

When the Academy issued its first report on Medical Assistance for the Aged, the Kerr-Mills bill and its enabling measure in New York State, the Metcalf-McCloskey bill, establishing provisions for MAA had already become law. The Academy, actuated by its desire that the program succeed, was concerned about the practicalities of its effectuation. It voiced its misgivings over where administrative authority was lodged, ventured a prediction, and formulated recommendations that it believed offered a blueprint for success. How prescient it was may be gleaned from this digest of its first report and the record of MAA:

> . . . Specifically, [the Academy's] interest centers upon the quality and quantity of medical care that will be provided to the beneficiaries. Both the criterion and the goal should be, the Academy believes, medical care that is satisfactory in quality and sufficient in quantity, but without excess.
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> In carrying out the program there are administrative duties such as determining eligibility, accounting and disbursing. But these should be incidental to the real purpose of the law, to provide medical care for the needy aged. For that purpose physicians are the key personnel. Under the law the program operates at two levels, state and local. The department in which authority and responsibility are vested at the state level determines the department controlling the program at the local level. . . . . But in the final analysis it is the private practitioner at the local level who actually renders the service.
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> Several potential difficulties may be foreseen in effectuating a program of medical care for the needy aged with an eligibility clause. These difficulties are not fancies or speculations about highly improbable eventualities. They are realities that have already occurred, some with considerable frequency. One is the cost of determining eligibility. . . . When the cost for determination of eligibility runs so high that it consumes a disproportionate amount of funds appropriated for medical care, it becomes a grave matter. . . .
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> The second difficulty is the overuse of medical service and hospitalization. When benefits are available on a mass scale, they are usually abused to a varying degree. . . . Overuse of hospitalization is probably the most troublesome problem in a medical benefit plan and it is difficult to control.
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> Equally disturbing but entirely different is the third problem arising in a medical care plan. It is the difficulty of a defect: inferior quality of medical care. The impression prevails that something may happen to the quality of medical service in the process of providing it on a mass scale. When the ingredients of indigency and governmental bounty are added, the result is not improved. . . .
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> . . . If a mass medical care program is to succeed it must have these provisions: 1) a unit controlled, directed and operated by professionals trained in medicine; 2) authority commensurate with responsibility; 3) organization and system; 4) standards and regulations governing the quantity and quality of medical care; 5) supervision to ensure adherence to standards and regulations. Too frequently in governmental programs these specifications are not met.
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> When a medical care program is entrusted to a governmental nonmedical department, it is apt to become a subordinate or side operation. Furthermore, such a department is not equipped by training to manage and direct it. . . . Actually the parent department retains the authority and funds; it buys and delegates performance of service. The physicians who in reality render the service have the ultimate responsibility without real authority. For, the hand that controls the funds holds the power

and authority. If such a program fails, all parties share in the blame, especially the physicians—not just the participating physicians but the entire profession.

The Academy is familiar with the argument that mainly the program presents an administrative task, so far as government is concerned, and that it is natural to have a welfare unit, that is already attending to the other needs of the indigent and marginal, take on the additional responsibility of providing medical care. By this line of reasoning it is evident that determining eligibility, accounting and disbursing are conceived to be the major and important part of the program, while provision of medical care is regarded as secondary. Such thinking surely contributes to the less than spectacular record of medical programs managed by welfare units. For, a medical need on a mass scale is a specialized need requiring specialized administration with autonomy, organization and professional knowledge. . . .

Apparently the sole reason for assigning the medical program for the needy elderly in New York State to the Department of Social Welfare was the requirement of eligibility. Since experience has indicated that determination of eligibility is likely to prove so costly that it will use up an excessive portion of available funds for medical care, the Academy believes that it becomes a self-defeating and unwarranted expenditure that threatens the medical care program. For this reason it favors elimination of the present type of determination of eligibility. It suggests that a new and much simpler method of determination of eligibility be devised that will be less costly to administer. . . .

To go one step further, the Academy is of the opinion that all programs providing direct medical service or hospitalization—except those for psychiatric disorders—and granting approval of hospitals should be incorporated into an independent unit. . . . In the aggregate these programs for medical care present such a specialized responsibility and have become of such magnitude that they constitute a primary enterprise requiring operation as a regular but separate unit of the state government under the authority and direction of qualified physicians.

The Academy would emphasize that in the administration of a program of medical care for the needy aged, authority and responsibility should not be separated. It should be organized as an internally autonomous unit completely directed and controlled by physicians; it is most important that it have standards and regulations; and it is equally essential that its operations be supervised. . . .

Rather than defer comment until the proposed program has been in operation long enough to yield results, The New York Academy of Medicine believes that its misgivings are sufficiently well-founded that it should present them at this time. Above all, it is desirous that the new law should succeed. In this spirit it holds that increasing the chances of success by constructive action at an early stage is better than correction of failure.

During the three years since the Kerr-Mills program became operative, the Committee has maintained a continuing and studious interest in this area. From time to time since MAA became law there have been statements on its growth and performance. To these have been added critical comments of its record. In the course of its study, the Committee noted the sharp differences of opinion which prevailed among officials and experts concerned with the problem. On one hand, there were those who said that the medical needs of the elderly were being met, or might be expected to be met within a reasonable time by existing provisions. Others argued that the entire program was inadequate and needed changes in one degree or another.

The most comprehensive critique has come from a Majority Report of a Congressional Committee which reviewed MAA after three years of operation. It was pointed out that it was the intent of Congress in instituting the MAA program to provide broad health services to the medically indigent aged. To achieve this objective, there were three essentials: all states should establish an MAA program; these state programs should include a comprehensive range of medical

services, which is permissible by the federal law; and these benefits should be available without unrealistic restrictions or difficulties.

But, it was maintained, Congress' intent had been thwarted. After three and one-half years MAA was still not a national program since it was operational in only 32 states. Benefits provided in most participating states were regarded by the Congressional Committee as inadequate. In many states the benefits had been restricted so that the total cost would not exceed the state appropriation. Deductible and coinsurance clauses inserted as some protection against overuse and overexpenditure had been imposed so unrealistically as to detract from the benefits. But, most significantly, excessive administration costs in nonmedical aspects, for example, expensive determination of eligibility, had in some instances left little money for medical benefits. Then too, in some states MAA had been little more than an institutional care program. In the most recent years 95 per cent is said to have been used for hospital and nursing-home care. Proportionately too little had been spent for physicians' services.

Although the medical needs of the aged are said to be fairly uniform throughout the nation, extreme divergences were found in the scope of the various state MAA programs. Monthly expenditures per person ranged from 22¢ in one state to $109.42 in another. The MAA program was found to cover 50 per cent of the elderly in one state and only 3 per cent in another. It was concluded that the elderly in similar circumstances are provided medical care according to geography, not according to their need.

In states with operating programs, limited participation by the elderly was found. In July 1963 it was reported that less than 1 per cent of the nation's elder citizens received MAA assistance. According to the New York State Department of Social Welfare, the percentage of elderly patients throughout the nation who received state health benefits actually had decreased since MAA was enacted.

The reasons advanced for this limited usage are the restrictive provisions; stringent eligibility tests in which resources usually must be depleted to near-dependence before acceptance; lien-type recovery stipulations; financial responsibility of relatives; deductible clauses; ceilings on state monies appropriated; limited benefits; mutual attitudes of welfare directors and hospitals; disagreement over the method of reimbursement; and lack of communication and publicity.

It could only be concluded that either there is limited participation because of restrictive provisions or that there is less need for medical care of the elderly than is asserted. Parenthetically, it should be noted that several states, some with comprehensive programs, found the demand for MAA less than predicted and ended their fiscal year with unused funds.

Other faults found with the operation of MAA were attributed to state administration. One serious defect in Title VI—Medical Services for the Aged (the Kerr-Mills amendment to Title I of the Social Security Act) is the restriction placed upon its administration as written into the law. Subsection 3 of Section 2 states: [A state plan for old-age assistance must] "(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan." Most state plans for MAA place its administration in the department of social welfare. Since a number of influences are weighted in this direction, this arrangement is understandable. After all, MAA

is a part of the Social Security Act and departments of social welfare are already administering OAA. Thus in practice this limitation to a single state agency imposed by federal law has been prejudicial and rigid. What it worse, it has been detrimental. Departments of social welfare are not trained to administer health services. On the other hand, departments of health or medical bodies that have the necessary training, experience, and qualifications to manage MAA can participate in the administration of the plan only upon invitation. They have played little part. Thus the group best equipped to administer MAA does not have the authority and seldom has the opportunity.

Furthermore, in addition to questionable qualification, it has been alleged that the plan was being administered by a hostile group. It has been asserted that the welfare departments have not been overzealous in making the program work satisfactorily.

For another thing, because of more favorable reimbursement arrangements for MAA, states were found to have shifted elderly patients from OAA to MAA rolls. MAA had thus become a vehicle for reducing state expenditures for the elderly sick. Some authorities assert that this was clearly not the intent of Congress. It is interesting to note that a representative of the American Medical Association denies that there has been any large transfer of patients from OAA to MAA rolls. Then follows a list of complaints against administrative practice: the time-consuming and costly investigation of eligibility; the restrictive and discriminatory nature of regulations; the abrupt issuance of regulations which perpetuates an air of uncertainty for all parties; formulas for reimbursement of hospitals which omit costs for which they feel they should be reimbursed; and delays in certification and payment.

This list of criticisms of the restricted and variable benefits, limited usage, and faults in operation of MAA is shown to originate in the state MAA laws and their administration. If improvement of these points is to be sought, it is clear that attention must be given to clarification of the federal law so that its intent and purpose are so clear and unmistakable that it will be readily interpreted and properly administered.

Toward this end, the following recommendations are proposed by the Committee as one way to fulfill the original intent of Congress in providing health services for the medically indigent aged:

1. There should be an attempt to fulfill the original intent and purpose of Title VI, the Kerr-Mills Act, of the federal law. This should be accomplished by proper interpretation and administration if possible, and if not, the federal law should be rewritten in more precise language so that it will be properly and adequately used, so that its administration will be effective, and so that loopholes permitting diversion of funds will be closed.

2. The goal of a national program could be achieved promptly if effectuation of an MAA plan were mandatory for each state. But it is highly probable that a direct measure by federal enactment would not be constitutional. However, unless all states assume their responsibility and put an adequate plan into effect without further delay, it would be justifiable to apply indirect measures. For example, states in default might by law incur a fiscal penalty, such as deprivation of federal funds for an essential related program, until they had fulfilled their

responsibility for an MAA plan.

3. The federal act should contain a specific provision that would place a floor under benefits. Each state should be required to provide the same acceptable minimum patient care. At least the minimum benefits would therefore be uniform across the nation. Any state would be free to provide benefits in excess of this minimum.

4. The federal law should specify basic requirements for eligibility that would be uniform for all states. These basic requirements should not be unrealistically restrictive. Any state could then be more liberal in its requirements but none could be more restrictive than the basic specifications.

5. The federal act should provide for removal of health services for the medically indigent aged from the welfare departments. These services should be placed under a separate medical unit or under health departments.

SUMMARY

The Committee accepts that an undetermined number of elderly are medically indigent. In the belief that illness should not impoverish, it was also concerned about those facing catastrophic illness. Medical care for the medically indigent should be complete and adequate for their needs. Its quality should meet the standard of good medical care prevailing in the community.

Choice of a system to provide financial help for the medically indigent will be among private insurance, public insurance, postpayment from general revenue. Two cardinal principles helped the Committee in making its selection: 1) provision of help with medical expenses of the present elderly and the future elderly are two different problems in financing; 2) no one system may be the most appropriate and effective for both. Each may require its own plan.

In addition it should be noted that two systems are already in effect. The Committee believes that they have not had a fair trial, not primarily because of insufficient time. To have a fair trial, both systems must be improved. Until the two systems have a fair trial, the Committee sees no point in introducing a third system, particularly one that is itself inadequate and necessitates establishing a new and probably large bureaucracy.

RECOMMENDATIONS

In the interest of achieving the best possible means of helping the medically indigent among the elderly, the Committee on Public Health recommends:

1. That private insurance and MAA be improved.

2. That private insurance should be improved in these ways:

That while continuing to offer health insurance for those already 65 or over, private insurance should place more emphasis on writing health insurance to be taken under 65 for protection after 65.

That for this group, policies with the broadest benefits and lowest premiums should be developed.

That private insurance companies should cooperate so that they would in effect constitute a national system.

3. That MAA should be improved by these measures:

That there should be an attempt to fulfill the original intent and purpose of Title VI of the federal law. This should be accomplished by proper interpretation and administration if possible and, if not, the federal law should be rewritten in more precise language so that it will be properly and adequately used, so that its administration will be effective, and so that loopholes permitting diversion of funds will be closed.

That the goal of a national program should be achieved promptly by effectuation of an MAA plan in each state. Unless all states assume their responsibility and put an adequate plan into effect without further delay, it would be justifiable to apply indirect measures toward that end.

That the federal act should contain a specific provision that would place a floor under benefits. Each state should be required to provide the same acceptable minimum patient care. At least the minmum benefits would therefore be uniform across the nation. Any state would be free to provide benefits in excess of this minimum.

That the federal law should specify basic requirements for eligibility that would be uniform for all states. These basic requirements should not be unrealistically restrictive. Any state could then be more liberal in its requirements but none could be more restrictive than the basic specifications.

That the federal act should provide for removal of health services for the medically indigent aged from the welfare departments. These services should be placed under a separate medical unit or under health departments.